Lothersdale Primary School

REQUEST FOR / Record of medicine administered to an individual child

*If more than one medication is to be given, then a separate form must be completed for each*

|  |
| --- |
| TO BE COMPLETED BY THE PARENT/CARER |
| **Name of School / Setting:** | LOTHERSDALE PRIMARY SCHOOL |
| **Name of child:** |  |
| **Class:** |  |
| **Medical condition/illness:** |  |
| **Medication name and strength:** |  |
| **Medication formula (eg. liquid/tablets):***Note: medication must be in the original container as dispensed by the pharmacy* |  |
| **Date medicine provided by parent/carer:** |  |
| **Dose and frequency/time of administration:** |  |
| **Details for storage:** |  |
| **Quantity received:** |  |
| **Administering instructions:** |  |
| **Any known side effects:** |  |

|  |
| --- |
| **PARENTAL STATEMENT OF CONSENT** |
| **I *(printed name of parent/carer)*** |  |
| * request and give my consent to Lothersdale Primary School administering this medication in accordance with the prescriber’s instructions
* confirm that the information and instruction given is accurate and up- to- date
* will inform the school in writing of any changes to this information and instructions
* understand that the medication may be given by non-medically qualified staff
* agree to not hold staff responsible for loss, damage or injury when undertaking agreed administration of the medication unless resulting from their negligence
* will abide by the school’s policy and procedure for the delivery and return of medication
* will ensure adequate supply of the medication that is within its expiry date
 |
| **Parent/Carer Signature:** |  | **Date:** |  |

|  |
| --- |
| **LOTHERSDALE PRIMARY SCHOOL STATEMENT OF AGREEMENT** |
| Lothersdale Primary School agrees to administer this medication* in accordance with the prescriber’s instructions
* until the end of the course of medication or until instructed otherwise in writing by the parent/carer
 |
| **Staff Signature:** |  | **Date:** |  |
| **Headteacher Signature:** |  | **Date:** |  |

**Note: The Headteacher must establish that the appropriate knowledge, training and insurance requirements for the giving of this medication are met before agreement is given.**

|  |
| --- |
| **RECORD OF MEDICINE ADMINISTERED BY STAFF TO AN INDIVIDUAL CHILD****(to be completed by the school)** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** |  |  |  |
| **Time given:** |  |  |  |
| **Dose given:** |  |  |  |
| **Name of member of staff:** |  |  |  |
| **Staff initials:** |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** |  |  |  |
| **Time given:** |  |  |  |
| **Dose given:** |  |  |  |
| **Name of member of staff:** |  |  |  |
| **Staff initials:** |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** |  |  |  |
| **Time given:** |  |  |  |
| **Dose given:** |  |  |  |
| **Name of member of staff:** |  |  |  |
| **Staff initials:** |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** |  |  |  |
| **Time given:** |  |  |  |
| **Dose given:** |  |  |  |
| **Name of member of staff:** |  |  |  |
| **Staff initials:** |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** |  |  |  |
| **Time given:** |  |  |  |
| **Dose given:** |  |  |  |
| **Name of member of staff:** |  |  |  |
| **Staff initials:** |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Date:** |  |  |  |
| **Time given:** |  |  |  |
| **Dose given:** |  |  |  |
| **Name of member of staff:** |  |  |  |
| **Staff initials:** |  |  |  |